

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First	Middle	Last	20. DATE OF DEATH Month Day Year	2b. HOUR 9:53 AM
JERELINE CATHERINE BAMBERGER				April 12, 1986	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH March 10, 1905		6. AGE (In years lost birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Caroline	Md.	
10. CITY OR TOWN OF DEATH Denton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 110 Randolph Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Denton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 110 Randolph St 21629	
14. FATHER'S NAME First Samuel	Middle McDonagh	Last	15. MOTHER'S MAIDEN NAME First Annie	Middle	Last unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213420443	17. INFORMANT Mrs. Jesse Leager, Price, MD	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Melignant Melanoma</i> 7 months DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Philip P. Felipe</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4/16/86	
22d. PHYSICIAN'S NAME (Type) Philip P. Felipe, M.D.	22e. ADDRESS Maryland 421 South Fifth Avenue, Denton,				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/18/86	23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery	23d. LOCATION (City or Town) Denton	(County) Caroline	(State) MD
24. FUNERAL DIRECTOR ADDRESS More Funeral Home, P.O. 121 and 4th Denton, MD	25a. REC'D BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE <i>Jeanne Anderson Pendleton</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN. The letter is to be signed by the hospital or attending physician.

measured within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon amateur. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury or other traumatic event, a medical examiner's certificate should be obtained.

BP _____
DMMH - 16 50M 4/83
(VRA 15.4)

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 11379
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>AGNES</i>	MIDDLE <i>K.</i>	LAST <i>BRAND</i>	2a. DATE OF DEATH MONTH YEAR	2b. HOUR 10:56 P.M.
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH YEAR Oct 1, 1889	6. AGE (IN YEARS LAST BIRTHDAY) 96			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Caroline			MD.	
10. CITY OR TOWN OF DEATH Denton, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wesleyan Health Care Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Dor.	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE rural route 2 21613		
14. FATHER'S NAME FIRST Samuel		MIDDLE Kirwan	LAST	15. MOTHER'S MAIDEN NAME FIRST Louisa	MIDDLE	LAST Clark	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 222-07-3737		17. INFORMANT Howard C. Elzey	ADDRESS Rt 2 Box 354 Camb.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/19 → 9/20							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ANEMIA; PARA PROTEIN ABNORMALITY							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 7/1/85 , 19_____, to 4/20 , 19_____, that (I) (we) last saw the deceased alive on 4/18/86 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>B. Grund</i>		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/21/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE M. GRUND		22e. ADDRESS Box 122 GOLDSBORO, MD 27629					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 4/23/1986	23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cem.	23d. LOCATION CITY OR TOWN Cambridge	23e. COUNTY Dor.	23f. STATE Md.		
24. FUNERAL DIRECTOR NAME Williams Funeral Home Camb. Md.		ADDRESS 624	25a. DATE REC'D. BY REGISTRAR APR 26 1986	25b. REGISTRAR'S SIGNATURE <i>John D. Johnson</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other significant event, the medical examiner should be notified of same.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 3 8 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hattie			FIRST Betty L.	MIDDLE Craig	LAST	2a. DATE OF DEATH MONTH 4 DAY 1 YEAR 1986	MONTH YEAR	DAY	YEAR	2b. HOUR M	
3. SEX Female			4. RACE White	5. DATE OF BIRTH MONTH 12 DAY 1 YEAR 1909	6. AGE (IN YEARS LAST BIRTHDAY) 76	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA	7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Caroline						
10. CITY OR TOWN OF DEATH Federalsburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 210 Academy Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home maker		
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 210 Academy Ave., Fed., Md.			
14. FATHER'S NAME FIRST Edward			MIDDLE F.	LAST Perry	15. MOTHER'S MAIDEN NAME FIRST Carrie			MIDDLE F.	LAST Callis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-20-7324			17. INFORMANT ADDRESS Edward F. Perry, Jr. Fed., Md.			21632		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic Heart Disease ?										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(c) DUE TO, OR AS A CONSEQUENCE OF General atherosclerosis ?										?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus, type II											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-5-85 , 19_____, to 4-1-1986 , that (I) (we) last saw the deceased alive on 2-28-1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) not view the body after death.											
22b. SIGNATURE IM Trapnell			22c. DEGREE			22d. DATE SIGNED 4/4/86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) H. R. Trapnell, M.D.			22f. ADDRESS 128 Bloomingdale Ave. Federalsburg, Md. 21632								
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 4-2-86			23c. NAME OF CEMETERY OR CREMATORIAL Bloomery Cem.			23d. LOCATION CITY OR TOWN Federalsburg COUNTY Caroline STATE Md. 21632		
24. FUNERAL DIRECTOR Williamson Funeral Home Fed., Md. 21632			25a. DATE REC'D. BY REGISTRAR APR 9 1986			25b. REGISTRAR'S SIGNATURE John D. Johnson, Jr.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove section 24 and file page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is marked or item 18 shows any injury or other traumatic event, the medical certificate must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
8 6 1 1 3 8 1 REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR			
James Alex Glessner						4-15-1986					7:45A M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH 6 DAY 1 YEAR 1906			79			MONTHS		DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Penns.		USA					Caroline							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Federalsburg		Old Hurlock Road		Machinist			Trucking							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21632	
Maryland		Caroline		Federalsburg						Old Hurlock Rd. Fed., Md.				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME										
Harry				Flora Pearl Coughenour										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			21632				
No		213-12-7988		Mr. Jack Glessner			Old Hurlock Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of prostate												7 months		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma, metastatic disease, generalized, all major organs														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/16 1985 to 4/15 1986 , that (I) () last saw the deceased alive on 4/7 1986 , and that in (my) () opinion death occurred on the date and hour and from the causes stated above. (I) () did (d) view the body after death.												22c. DATE SIGNED 4/15/86		
22b. SIGNATURE <i>R. H. Beckert, M.D.</i>												DEGREE		
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS												
R. H. Beckert, M.D.		P.O. Box 278, Bridgeville, Dela. 19933												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE				
Cremation		4-15-86		Delmarva Crematory			Lewis			Sussex Delaware				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Williamson Funeral Home		Fed., Md.												
APR 22 1986 <i>Julia Davidson-Randall</i>														

Planning for motion

Figure 5.10. The effect of a 10% increase in the interest rate on the value of the firm.

Edition 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First Alvin	Middle Chester	Last Shaffer	2a. DATE OF DEATH 4 Month 28 Day 86 Year	2b. HOUR 8:15 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH March 15, 1909		6. AGE (in years last birthday) 77 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Caroline County	Md.	
10. CITY OR TOWN OF DEATH Denton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Denton-Harrington Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Denton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Denton-Harrington Rd	
14. FATHER'S NAME First John	Middle H.	Last Shaffer	15. MOTHER'S MAIDEN NAME First Carrie	Middle Hostetler	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 213039033	17. INFORMANT Mrs. Gladys Collison, Denton, MD	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (1) (this hospital) attended the deceased from 9-6 , 19 86 , to 4/28 , 19 86 , that (1) (we) last saw the deceased alive on 4-9 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David S. Smith	22c. DATE SIGNED 4/28/86				
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS PO Box 660 Denton, MD				
23a. BURIAL, CREMATION, BURIAL (Type or print)	23b. DATE 4/30/86	23c. NAME OF CEMETERY OR CREMATORIUM Denton Cemetery	23d. LOCATION (City or Town) Denton	(County) Caroline	(State) MD
24. FUNERAL DIRECTOR Moore Funeral Home, P.O. Box 660 Denton	ADDRESS Moore Funeral Home, P.O. Box 660 Denton	25a. REC'D. BY REGISTRAR MAY 01 1986		25b. REGISTRAR'S SIGNATURE John J. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return ~~the~~ ~~original~~ papers, Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other ~~abnormal~~ condition, the medical examiner may make a medical examination.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86	1383	
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST AMELIA MIDDLE SADIE SWANHAUS			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR 05 22 1886			6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CAROLINE					
10. CITY OR TOWN OF DEATH Denton md.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wesleyan Health Care Centre			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE					
13a. STATE Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Hawthorne			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 352 21643		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD CLARKE MARSHALL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY B. SEARS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-32-6537			17. INFORMANT ADDRESS ST. MICHAELS, Md. ROBERTA H. MARSHALL P.O. BOX 495 21663		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 HR		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) AGE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (CHRONIC)														
(c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. POSSIBLE BRONCHOPNEUMONIA VS. CHF (CONGESTIVE HEART FAILURE)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 316			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 7/1, 1985, to 4/16, 1986, that (I) (we) last saw the deceased alive on 3/6, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE Bruce M. Grund			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/18/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce M. Grund			22e. ADDRESS Box 122 GOLDSBORO, MD. 21636											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE APRIL 19, 1986			23c. NAME OF CEMETERY OR CREMATORIAL OLIVET CEMETERY			23d. LOCATION CITY OR TOWN ST. MICHAELS, TALBOT, MARYLAND					
24. FUNERAL DIRECTOR NAME - Garrison E. Leonard, Jr. Mackeals, Jr.			ADDRESS						25a. REGISTRAR 25b. REGISTRATION SIGNATURE					

0-01830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic cause, the medical examiner must be notified or advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
8 6 1 1 3 8 4											REG. NO.					
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
WILLIAM GEORGE TOWERS									April 4, 1986						6:30a.m.	
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR Feb 22, 1900			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD							
10. CITY OR TOWN OF DEATH Denton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 206 North Sixth Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Mechanic							
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Denton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 206 North Sixth St. 21629				
14. FATHER'S NAME FIRST MIDDLE LAST George William Towers						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Callahan										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218244446			17. FORMER ADDRESS Mrs. Irene Towers, Denton, MD Mr. Charles Davis, Denton, MD						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death</u> DOUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVOD</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) DOUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (1) this hospital attended the deceased from <u>3-26 1986</u> to <u>3-7-6 1986</u> , (2) we last saw the deceased alive on <u>3-26 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>David S. Smith, M.D.</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4-4-86										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David S. Smith, M.D.			22e. ADDRESS Kerr Ave., Denton, Maryland 21629													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/7/86			23c. NAME OF CEMETERY OR CREMATORIAL Concord Cemetery			23d. LOCATION CITY OR TOWN Denton			COUNTY Caroline	STATE MD			
24. FUNERAL DIRECTOR NAME Maurice Funeral Home, P.A.			ADDRESS 123 Main St., Denton			25a. DATE REC'D. BY REGISTRAR APR 8 1986			25b. REGISTRAR'S SIGNATURE Julie K. Johnson, R.N.							

VOIDED DEATH CERTIFICATE FOR

MARTHA ELLEN UHRIG - CAROLINE CO. -

MARCH 28, 1986 -- Certificate Number - 86-11385

SEE MAY, 1986 DEATHS



0-03522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please return certificate to funeral director. Then please return certificate to funeral director. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified of same.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 | 3 8 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
MATILDA LOUISE WERNER						April 7, 1986				5:40 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Female		Caucasian		June 26, 1895		90				YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.							
Pennsylvania		U. S. A.											
10. CITY OR TOWN OF DEATH Denton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wesleyan Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor				12b. KIND OF BUSINESS OR INDUSTRY Laundry			
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Denton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Bloxom Road		21629			
14. FATHER'S NAME FIRST Dennis		MIDDLE Werner		LAST		15. MOTHER'S MAIDEN NAME FIRST Elizabeth		MIDDLE		LAST Ellman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO OR UNKNOWN		16b. SOCIAL SECURITY NO. No		16c. ADDRESS		17. INFORMANT J. Allen Werner, Ridgeley, MD							
16b. SOCIAL SECURITY NO. 220448618													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> , 19 <u>83</u> , to <u>6/26/86</u> , that (I) (we) last saw the deceased alive on <u>6/26</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>David S. Smith, M.D.</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/9/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David S. Smith, M. D.		22e. ADDRESS Kerr Avenue, Denton, Maryland 21629											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/10/86		23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery		23d. LOCATION CITY OR TOWN Denton		CITY OR TOWN Caroline		STATE MD			
24. FUNERAL DIRECTOR NAME Mac's Funeral Home, P.A.		ADDRESS 126 2nd St. Denton		25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE <u>John L. Lusk, Jr.</u>							

REG. NO.

337

00-04126

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN LINE 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRACTEE FORM, PAGES 1, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MISSION SEVITAI RECORDS 201 W BICKELMAN ST BALTIMORE MD 21201

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE			LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH DAY YEAR			2b. HOUR				
James E.		Westmoreland					<input checked="" type="checkbox"/> 4 4 19 86		4 4 19 86			4 24 P.M.				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. IF UNDER 24 HRS.		MONTH DAY			YEAR		2d. HOUR			
MALE	WHITE	MAY 1, 1913		73 yrs.		MONTHS DAYS HOURS MIN.		MONTH			DAY		YEAR			
7a. BIRTHPLACE (STATE OR PROVINCE AND COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
STOKES CO. N.C.		U.S.A.					CAROLINE COUNTY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
E. of DENTON		HOBBS ROAD			SALESMAN (AUTO)											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		MD						
DELAWARE		KENT		GREENWOOD		R-2 Box 143-B10		99999								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
?				WESTMORELAND		CORA		??		Westmoreland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
YES		1944-246-07-1119			Floy Westmoreland		Greenwood, Dela									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) <u>Surgical Shock - EXANGUINATION</u>																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>3/4 Decapitation</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Auto accident</u>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION											
		Hobbs Road			EAST OF DENTON		CITY OR TOWN		COUNTY		STATE					
							Car left road + Overturned		Caroline		Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																
death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		Louis S. WELTY			TITLE (SPECIFY)											
EXAMINER'S NAME (TYPE OR PRINT)		Louis S. WELTY			M.D. for D.P.		MEDICAL EXAMINER									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE						
BURIAL		4/9/86		TODD'S Chapel Cemetery		Greenwood		Delaware								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
William FLEISCHHAUER		GREENWOOD, De		APR 18 1986												

DMMH - 17
(VR A15 ME (5))

